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Legislative Bulletin……..……December 19, 2007

Contents:

S. 2499 — Medicare, Medicaid, and SCHIP Extension Act of 2007
(Sen. Baucus, D-MT)

Order of Business: The bill is scheduled to be considered under suspension of the rules on Wednesday, December 19, 2007. The Senate introduced and passed the bill on Tuesday, December 18, by unanimous consent.

Summary: S. 2499 eliminates for six months a reduction in Medicare physician payments scheduled to take effect on December 31, 2007, providing a 0.5% increase through June 30, 2008. S. 2499 also extends the State Children's Health Insurance Program through March 31, 2009, and provides additional funding to cover currently eligible children, without expanding or extending eligibility definitions beyond current cohorts.

Medicare: S. 2499 contains many provisions that alter Medicare, Medicaid, and SCHIP law as follows:

Update for Medicare Physician Services. S. 2499 would provide a 0.5% update to the conversion factor for physician reimbursements for the six months ending June 30, 2008, at a cost of $6.4 billion over ten years. In November, the Centers for Medicare and Medicaid Services (CMS) announced that the annual update to the conversion factor for 2008 would be negative 10.1%, as spending on physicians' services and other Part B services has been growing at a much faster rate than target spending. Providing a 0.5% update to the conversion factor would ensure that the -10.1% update does not go into effect. *CBO estimates that this provision will cost $6 billion over ten years.* To learn more on the background of this provision and details of the conversion factor and Sustainable Growth Rate (SGR), please read the section below entitled *"Additional Background."*

Bonus and Quality Reporting. The bill extends a physician quality reporting system, as well as 5% bonus payments to physicians practicing in physician shortage areas through June 30, 2008. In recent years there has been a large government push to require pay for performance standards tied to physicians' Medicare reimbursement payments in order to control spiraling medical costs. This would require physicians to report on minute aspects of the doctor-patient interaction so the

government could review and measure quality of care to set reimbursement levels. This issue is controversial, as there has been no discussion on who sets the "quality standards" and who would define what quality looks like under such a system. Opponents of quality reporting provisions would argue that quality of care can only be determined by patients and physicians.

Extension for Other Provider Payments. In addition to the adjustment to the SGR conversion factor, S. 2499 would extend provisions related to physician pathology services (*no net cost*), clinical laboratory tests in rural areas (*no net cost*), and therapy caps (*net cost of $200 million*) through June 30, 2008. The legislation also adjusts the reimbursement rate for diabetes laboratory tests approved for home use (*net cost of $700 million*) and brachytherapy (*no net cost*) services beginning April 1, 2008.

Medicare Advantage Enrollment. The bill would extend the authority for certain existing Medicare Advantage plans to count as "special needs plans" – those plans serving institutionalized patients, or beneficiaries with severe or disabling chronic diseases – and target enrollment to specialized populations through December 31, 2009. However, the bill would also preclude the Secretary from designating any new such plans, and would prohibit beneficiaries from enrolling in any expanded service areas by existing plans through December 2009. *CBO scores this provision as costing $1.4 billion over ten years*.

Reduction in Medicare Stabilization Fund. S. 2499 would remove the remaining $1.5 billion from the Medicare stabilization fund for regional provider organizations in 2012. It is important to note that unlike numerous Democrat Medicare and SCHIP bills, this legislation does not cut payments to Medicare Advantage plans, which has provoked past veto threats, because doing so would discourage many private plans from participating in the program, perhaps eliminating the private Medicare option in many areas and for many individuals.

Medicare Secondary Payer. The bill includes additional requirements on group insurance plans and liability insurers to the Secretary to determine that the beneficiary is entitled to benefits under the Medicare Secondary Payer program. *CBO scores this provision as saving $1.1 billion over ten years*.

Average Sales Price Computation. S. 2499 would establish a volume-weighted average sales price for prescription drugs based on average sales volume. *CBO scores this provision as saving $2.6 billion over ten years*.

Long-Term Care Provisions. The bill would freeze the market-basket reimbursement rate for long-term care (LTC) facilities for the last quarter of 2008, *saving $1.2 billion over ten years*. Additionally, S. 2499 would establish new review requirements on long-term care facilities to ensure patients are receiving appropriate levels of care, and impose a limited moratorium on the development of additional long-term care facilities. Some conservatives may be concerned that these provisions, by preventing the development of additional long-term care facilities, represent an unnecessary government intervention in the LTC market.

Reduction in Inpatient Rehabilitation Services. The legislation reduces the market basket update factor for inpatient rehabilitation facilities (IRFs) at 0% from April 1, 2008 through Fiscal Year 2009, *saving $4 billion over ten years*.

Medicare Payment Advisory Commission. S. 2499 would change the status of the Medicare Payment Advisory Commission (MedPAC) – an agency that submits reports and recommendations to Congress regarding payment policy, access to care, quality of care, and related issues affecting Medicare – from that of an independent agency to an agency of Congress.

Medicaid and SCHIP:

Extension of Qualifying Individual Program. The bill would extend the qualified individual (QI) program, which provides assistance through Medicaid for low-income seniors in paying their Medicare premiums, through June 30, 2008, *at a cost of $200 million over ten years*.

TMA and Title V Extension. S. 2499 would extend for six months (until June 30, 2008), both the authorization for Title V programs (abstinence education programs), and the authorization for Transitional Medical Assistance (Medicaid benefits for low-income families transitioning from welfare to work), *at a cost of $400 million over ten years*. TMA has historically been extended along with the Title V Abstinence Education Program. Regarding the Title V grant program, in order for states to receive Title V block grant funds, states must use the funds exclusively for teaching abstinence. In addition, in order to receive federal funds, a state must match every $4 in federal funds with $3 in state funds.

SCHIP Extension and Funding. The bill extends the State Children's Health Insurance Program through March 31, 2009, to allow for a reauthorization process that does not become entangled in the 2008 election season. The bill also provides supplemental funding for states that are expected to exhaust their SCHIP funding at current levels. (See *"Additional Background."*) *This provision has a net cost of $800 million, according to CBO*.

Additional Background:

Medicare. Under current Medicare law, doctors providing health care services to Part B enrollees are compensated through a "fee-for-service" system, in which physician payments are distributed on a per-service basis, as determined by a fee schedule and an annual conversion factor (a formula dollar amount). The fee schedule assigns "relative values" to each type of provided service. Relative value reflects physicians' work time and skill, average medical practice expenses, and geographical adjustments. In order to determine the physician payment for a specific service, the conversion factor ($37.8975 in 2006) is multiplied by the relative value for that service. For example, if a routine office visit is assigned a relative value of 2.1, then Medicare would provide the physician with a payment of $79.58 for that service. ($37.8975 x 2.1)

Medicare law requires that the conversion factor be updated each year. The formula used to determine the annual update takes into consideration the following factors:

- Medicare economic index (MEI)–cost of providing medical care;

- Sustainable Growth Rate (SGR)–target for aggregate growth in Medicare physician payments; and
- Performance Adjustment–an adjustment ranging from -13% to +3%, to bring the MEI change in line with what is allowed under SGR, in order to restrain overall spending.

Every November, the Centers for Medicare and Medicaid Services (CMS) announces the statutory annual update to the conversion factor for the subsequent year. The new conversion factor is calculated by increasing or decreasing the previous year's factor by the annual update.

From 2002 to 2007, the statutory formula calculation resulted in a negative update, which would have reduced physician payments, but not overall physician spending. The negative updates occurred because Medicare spending on physician payments increased the previous year beyond what is allowed by SGR. The SGR mechanism is designed to balance the previous year's increase in physician spending with a decrease in the next year, in order to maintain the aggregate growth targets. Thus, in light of increased Medicare spending in recent years, the statutory formula has resulted in negative annual updates. It is important to note that while imperfect, the SGR was designed as a cost-containment mechanism to help deal with Medicare's exploding costs, and to some extent it has worked, forcing offsets in some years and causing physician payment levels to be scrutinized annually as if they were discretionary spending.

Since 2003, Congress has chosen to override current law, providing doctors with increases each year, and level funding in 2006. In 2007, Congress provided a 1.5% update bonus payment for physicians who report on quality of care measures; however, Congress also provided that the 2007 "fix" would be disregarded by CMS for the purpose of calculating the SGR for 2008, resulting in a higher projected cut next year. The specific data for each year is outlined in the following table.

Year	Statutory Annual Update (%)	Congressional "Fix" to the Update (%)*
2002	-5.4	-5.4**
2003	-4.4	+1.6
2004	-4.5	+1.5
2005	-3.3	+1.5
2006	-4.4	0
2007	-5.0	+1.5***
2008	-10.1§	0.5 (proposed)

* The annual update that *actually went into effect* for that year.
** CMS made other adjustments, as provided by law, which resulted in a net update of - 4.8%; however, Congress did not act to override the -5.4% statutory update.
*** The full 1.5% increase was provided to physicians reporting quality of care measures; physicians not reporting quality of care received no net increase.
§ The Tax Relief and Health Care Act signed last year provided that 2007's Congressional "fix" was to be disregarded for the purpose of calculating the SGR in 2008 and future years.

SCHIP. According to a November Congressional Research Service report, 21 states are projected to face SCHIP shortfalls in the absence of additional funding for Fiscal Year 2008. However, at least nine of these states' shortfalls stem in part from their decisions to cover children in families making above 200% of the federal poverty level and/or to cover adults using the enhanced SCHIP funding match. A Heritage Foundation analysis of the CRS data notes that "these overextended [state] programs…account for the lion's share of the [SCHIP] shortfall." Some conservatives may have concerns that additional funding is being provided to cover the additional expenditures of states that have chosen to exceed the originally intended parameters of the SCHIP program.

Cost to Taxpayers: S. 2499 eliminates a scheduled 10.1% reduction in payments to physicians effective December 31, 2007, at a cost of $6.4 billion. The bill also includes $800 million in additional SCHIP funding to eliminate shortfalls through March 31, 2009. This new spending is offset by rescinding $1.5 billion from the Medicare stabilization fund, which finances payments to regional preferred provider organizations. S. 2499 also reduces payments to long-term care hospitals and inpatient rehabilitation facilities in 2008, saving an additional $5.2 billion over ten years. These and other changes make S. 2499 technically compliant with PAYGO rules.

Committee Action: The bill has not been considered by a House Committee.

Administration Position: The Administration has indicated no opposition to the measure.

Does the Bill Expand the Size and Scope of the Federal Government?: No.

Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?: No.

Does the Bill Comply with House Rules Regarding Earmarks/Limited Tax Benefits/Limited Tariff Benefits?: An earmarks/revenue benefits statement required under House Rule XXI, Clause 9(a) was not available at press time.

Constitutional Authority: A committee report citing constitutional authority is unavailable.

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